**Senior Farmers' Market Nutrition Program – Service Provider Agreement**
Form 1.2.11. (Rev. 04.2025)
State of California
California Department of Food and Agriculture
Office of Grants Administration

# SFMNP Service Provider Agreement – AAA and Provider

**THIS AGREEMENT** is effective during the year_____.

**BETWEEN:**

1. The Area Agency on Aging (AAA), PSA_____and,
2. _____ (Service Provider).

**THE AAA, PSA_____AGREES TO:**

1. Provides SFMNP Farmers' Market Cards to the Provider for distribution to eligible SFMNP participants.
2. Ensure Provider staff are trained on the issuance software, instructional SFMNP Toolkit and materials.
3. Provide SFMNP redemption rates.

**THE_____** (Provider) **AGREES TO:**

1. Follow the federal SFMNP regulations and procedures described in the SFMNPToolkit.
2. Ensure the Provider organization is neither debarred nor suspended and will notify AAA immediately if the Provider organization becomes debarred or suspended in the future.
3. Control the receipt and security of SFMNP Farmers' Market Cards.
4. Identify and certify SFMNP participant eligibility.
5. Ensure Self Certification Log is complete and filled out accurately.
6. Issue SFMNP Farmers' Market Cards to eligible participants.
7. Advise participants of their Rights and Responsibilities under the SFMNP.
8. Provide participants with nutrition materials on the use and safe handling of produce.
9. Display USDA, FNS "Justice For All" poster with Non-Discrimination Statement at SFMNP Farmers' Market Card issuance sites.
10. Ensure all Provider staff administering the SFMNP receive training on SFMNP issuance software, requirements, and policies and procedures.
11. Return all SFMNP documentation, forms, and unissued Farmers' Market Cards to the AAA.
12. Report to the AAA on the total number of Farmers' Market Cards distributed by October 15.

By signing the agreement, the Provider acknowledges that the AAA cannot provide funds to administer the SFMNP and certifies that the Provider is neither suspended nor debarred from receiving federal funds.

| **Area Agency on Aging – PSA _____** | **Service Provider Organization:** |
|---|---|
| **Name of Representative:** | **Name of Representative:** |
| **Agency:** | **Organization Name:** |
| **Address:** | **Address:** |
| **City, State, Zip:** | **City, State, Zip:** |
| **Email:** | **Email:** |
| **Authorized Signature & Date:** | **Authorized Signature & Date:** |